SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Filing at a Glance

Company: Fidelity Security Life Insurance Company

Product Name: Excess Loss Application	SERFF Tr Num: FDLT-126073799	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 41853
Sub-TOI: H21.000 Health - Other	Co Tr Num: A-01050AR(3/09)	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Tara Wilson, Kelly Humiston, Teresa Saling, Janice Garmon, Jennifer Glaser	Disposition Date: 03/19/2009
	Date Submitted: 03/18/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Excess Loss Application

Project Number: A-01050AR(3/09)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/19/2009

Deemer Date:

Filing Description:

RE: Fidelity Security Life Insurance Company

NAIC #71870 FEIN #43-0949844

Excess Loss Insurance

A-01050AR(3/09)

PA-00011AR

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: This filing will not be solicited in our domicile state of Missouri.

Market Type:

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 03/19/2009

Corresponding Filing Tracking Number:

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

PA-00004AR-CON

We respectfully submit the above-referenced forms for your review and approval. These forms are being filed to add the notice requirement as noted in Bulletin No. 6-2008.

Form A-01050AR(3/09) replaces form A-01050AR, which was approved by Arkansas on January 12, 2006; form PA-00011AR replaces form PA-00011 which was approved by Arkansas on June 14, 1999; and form PA-00004AR-CON replaces form PA-00004-CON, which was approved by Arkansas on February 11, 1993.

These forms will be used with Excess Loss products available in your state. The only change was to add the above-referenced notice.

Variable information is indicated by brackets { }. The variables are to be read as though the phrase is in, out, or the choices shown. The variables will not be adjusted to be less favorable than your state allows.

If you have any questions or require additional information, please feel free to telephone me at (800) 648 8624, extension 1639, or E-mail me at khumiston@fslins.com.

Company and Contact

Filing Contact Information

Kelly Humiston,
3130 Broadway
Kansas City, MO 64111-2406

khumiston@fslins.com
(816) 968-0639 [Phone]
(816) 968-0657[FAX]

Filing Company Information

Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64111-2406
(800) 648-8624 ext. [Phone]

CoCode: 71870
Group Code: 451
Group Name:
FEIN Number: 43-0949844

State of Domicile: Missouri
Company Type: Life & Health
State ID Number:

Filing Fees

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	3 Applications at $20 per form=$60.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Fidelity Security Life Insurance Company	$60.00	03/18/2009	26513954

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/19/2009	03/19/2009

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Disposition

Disposition Date: 03/19/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Excess Loss Reimbursement Contract	Approved-Closed	Yes
Form	Request for Participation	Approved-Closed	Yes
Form	Request for Continued Participation	Approved-Closed	Yes

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Form Schedule

Lead Form Number: A-01050AR(3/09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	A-01050AR(3-09)	Application/Enrollment Form	Application for Excess Loss Reimbursement Contract	Initial			A-01050AR(3-09).pdf
Approved-Closed	PA-00011AR	Application/Enrollment Form	Request for Participation	Initial			PA-00011AR.pdf
Approved-Closed	PA-00004AR-CON	Application/Enrollment Form	Request for Continued Participation	Initial			PA-00004AR-CON.pdf

FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway
Kansas City, Missouri 64111

APPLICATION FOR EXCESS LOSS REIMBURSEMENT CONTRACT

GENERAL INFORMATION

1. Full Legal Name of Applicant: _____
   Address of Applicant: _____
   City: _____ State: _____ Zip Code: _____
2. Type of Entity: ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ Limited Liability Co. ☐ Trusteeship ☐ Proprietorship ☐ Other: _____
3. Requested Effective Date: _____
4. Other Locations: _____
5. Primary Contact at Applicant: _____
6. Full Legal Name of Subsidiary or Affiliated Companies to be included: _____
   Address: _____
   City: _____ State: _____ Zip Code: _____
7. Nature of Applicant's Business: _____ SIC Code: _____
8. Full Name of Applicant's Plan: _____
   (A signed copy of such Plan must be attached and form a part of this Application.)
9. Name and Address of Third Party Administrator: _____
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Social Security No. or Tax ID: _____ Phone Number: _____
10. Name and Address of Writing Agent: _____
    (Attach a current copy of license(s) if not on file.)
    Address: _____
    City: _____ State: _____ Zip Code: _____
    Social Security No. or Tax ID: _____ Phone Number: _____

11. Estimated initial enrollment: _____ Single: _____ Family: _____
    Spouse Only: _____ Spouse & Children _____ Children only: _____

12. Deposit Premium: _____

13. Covered Persons Included in your Plan:	Yes	No
Retired Employees	☐	☐
COBRA Beneficiaries	☐	☐
Disabled Persons	☐	☐

SPECIFIC EXCESS LOSS INSURANCE ☐ Yes ☐ No

1. Plan Benefit Payments included in Your Plan to be covered by Specific Excess Loss Insurance:
   ☐ Medical ☐ Prescription Drug Expenses ☐ Other(s) _____
   ☐ Dental ☐ Vision
2. Contract Basis: Expenses Incurred from _____ through _____
   Paid from _____ through _____
3. Run-in claims Incurred prior to the Effective Date will be limited to $ _____
4. Specific Deductible (per Covered Person) $ _____
5. Specific Reimbursement Maximum: $ _____
   (per Covered Person excess of Specific Deductible)
6. Specific Percentage Reimbursable (excess of Specific Deductible) _____ %
7. Aggregating Specific ☐ Yes ☐ No
   If yes, the Aggregating Specific amount is $ _____

8. SPECIFIC MONTHLY PREMIUM RATES:

Single	{Family}	{Spouse only	Spouse & Child(ren)	Child(ren only}

AGGREGATE EXCESS LOSS INSURANCE ☐ **Yes** ☐ **No**

1. Plan Benefit Payments included in Your Plan to be covered by Aggregate Excess Loss Insurance:
   ☐ Medical ☐ Prescription Drug Expenses ☐ Other(s) _____
   ☐ Dental ☐ Vision
2. Contract Basis: Expenses Incurred from _____ through _____
   Paid from _____ through _____

3. Run-in claims Incurred prior to the Effective Date will be limited to $ _____
4. Aggregate Reimbursement Maximum (excess of Aggregate Annual Deductible): $ _____
5. Aggregate Percentage Reimbursable (excess of Aggregate Annual Deductible): _____ %

6. AGGREGATE MONTHLY FACTOR(S)

Plan Benefits	Single	{Family}	{Spouse only	Spouse & Child(ren)	Child(ren only}
Medical					
Dental					
Vision					
Prescription Drug Expenses					
Composite					

7. Minimum Aggregate Annual Deductible $ _____
8. Loss Limit (per Covered Person) $ _____
9. Monthly Aggregate Premium Rate (per Covered Person) $ _____
10. **Monthly Aggregate Accommodation** Option: ☐ YES ☐ NO
    If Yes, Monthly Aggregate Accommodation Premium (per Covered Person) $ _____
11. **Terminal Aggregate Liability** Option: ☐ YES ☐ NO
    If Yes, Monthly Terminal Aggregate Liability Premium (per Covered Person) $

{MEDICAL DATA

The Company will rely on the data below to assist in approving the Employer for Reimbursement. Note that without the Company's review and approval of each risk, the Participating Employer's Losses will not be reimbursable under the Excess Loss Reimbursement Contract; therefore, please answer the following questions.

1. Has an eligible employee or dependent received or expected to receive more than 50% of the Specific Deductible in expenses in the last 12 months? ☐ Yes ☐ No
2. Will any former employee or dependent be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? ☐ Yes ☐ No

If yes to questions 1 or 2, list name, status, prognosis, and amount of claim (attach, sign and date a separate sheet if needed):

Name _____ DOB _____ Sex: ☐ Male ☐ Female Status _____ (Ee, Dep, COBRA, Retiree)

Diagnosis _____

Prognosis _____

Amount of Claim _____

3. Are expected benefits available from the prior insurer for presently disabled eligible employees and/or dependents? ☐ Yes ☐ No
4. Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? ☐ Yes ☐ No

Please explain any "Yes" answers to questions 3 or 4 (Please attach, sign and date a separate sheet if needed):

}

SPECIAL LIMITATIONS:

DISCLOSURE

The Excess Loss Reimbursement Contract Employer Disclosure Statement must be received no earlier than 15 days prior to the effective date and no later than 15 days after the effective date. The Company reserves the right to adjust the rates, factors, deductibles and/or Special Limitations based upon information contained therein.

SIGNATURE

Application is hereby made for Specific and Aggregate Excess Loss Insurance through Fidelity Security Life Insurance Company ("Company"). This Application must be accepted and approved by the Company or its authorized representative prior to any Policy being in existence.

It is understood and agreed by the Applicant that:

1. the Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;

2. the Plan Administrator or Third Party Administrator retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent;

3. all documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within ninety (90) days of the Effective Date;

4. the Company will evaluate the Applicant's risk, and may require adjustments of rates, factors, deductibles and/or Special Limitations to accommodate for abnormal risks;

5. premiums are not considered paid until the premium check or transfer is received by the Company and at the rates set forth in the Schedule;

6. this Application will be attached to and made a part of any Excess Loss Reimbursement Policy issued by the Company in connection with this Application;

7. the Applicant's Plan Document shall be the basis of any Excess Loss Insurance provided by the Company and such Plan Document conforms with applicable State and Federal laws;

8. any reimbursement under the Excess Loss Reimbursement Policy provided by the Company shall be based on eligible Plan Benefits Paid in accordance with the Plan Document;

9. claims under the Plan Document for any employee who is not at his or her customary place of employment (or scheduled vacation) on the Effective Date of the Excess Loss Reimbursement Policy will not be eligible for reimbursement under the Policy until such employee returns to active, full-time employment for at least one (1) full working day;

10. unless otherwise indicated above, claims under the Plan Document for any Covered Person who is confined in a medical facility on the Effective Date of the Excess Loss Reimbursement Policy will not be eligible for reimbursement under the Policy until such person is discharged from the hospital or similar facility; and

11. if there is any material change in the answers to the questions in this Application or the Excess Loss Reimbursement Contract Employer Disclosure Statement before the Policy effective date, the Applicant must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

I represent that as of the date I signed this Application, all statements and answers recorded on this Application are true and complete and are made to obtain the insurance applied for and that the undersigned has the authority to bind the Applicant to the proposed contract. These statements are to be considered representations and not warranties. Accordingly, this Application will be part of the Contract if accepted by the Company or its authorized representative.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this _____ day of _____

Witness _____ Applicant _____
Signature of Licensed Agent (Type or Print)

_____ Applicant's Tax ID # _____
(Print Name)

By _____
(Officer/Partner Signature)

_____
(Print Name)

Title: _____

For Office Use Only:
Acceptance

Accepted on behalf of the Company this _____ day of _____ 20_____

By: _____ Title: _____

Policy No.: _____ Effective Date: _____

FIDELITY SECURITY LIFE INSURANCE COMPANY
(the "Company")
REQUEST FOR PARTICIPATION IN THE
{NATIONAL EMPLOYER'S EXCESS TRUST}
FOR EXCESS LOSS REIMBURSEMENT COVERAGE

EMPLOYER INFORMATION

Full Legal Name of Employer	Employer is a: ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ Proprietorship ☐ Trusteeship ☐ Other:_____
Street Address	
City State ZIP Code	Requested Effective Date:
Other locations:	
Key Contact Person at Employer:	
Full Legal Name of Subsidiary or Affiliated companies (companies under the common control through stock ownership, contract, or otherwise) to be included:	Address of Subsidiary or Affiliates:
Nature of Employer's Business:	
Full Name of Employee Benefit Plan(s). (A signed copy of such Plan must be attached an form part of this Request.):	
Total Eligible Employees:	Deposit Premium:
Estimated Initial Enrollment: Single Family Composite (Total)	

EMPLOYER'S THIRD PARTY ADMINISTRATOR

Name:	Address:
Phone No.:	Fax No.:

LICENSED WRITING AGENT (Attached current copy of license(s) if not on file)

Name:	Address:
Social Security No. or Tax ID	

AGGREGATE EXCESS INSURANCE

Accepted? ☐ Yes ☐ No

Benefit Period: Eligible Employer Losses from Plan
Incurred from_____ through_____ and
Paid from_____ through_____

Aggregate Excess Loss includes (Not included unless checked):
☐ Medical ☐ Dental Care ☐ Vision Care
☐ Prescription Drugs ☐ Weekly Disability Income
☐ Other_____

Losses incurred prior to the Effective Date will be limited to the amount reimbursable as set forth in the Schedule.

Aggregate Percentage Reimbursable (excess of deductible) _____%
Minimum Aggregate Deductible $_____
Loss Limit Per Person $_____
Maximum Aggregate Benefit (excess of deductible $_____
Monthly Aggregate Excess Loss ☐ Yes ☐ No
Aggregate Terminal Liability ☐ Yes ☐ No

SPECIFIC EXCESS LOSS INSURANCE

Accepted? ☐ Yes ☐ No

Benefit Period: Eligible Employer Losses from Plan
Incurred from_____ through_____ and
Paid from_____ through_____

Specific Excess Loss includes (Not included unless checked):
☐ Medical ☐ Prescription Drugs
☐ Other_____

Losses incurred prior to the Effective Date will be limited to the amount reimbursable as set forth in the Schedule.

Specific Deductible (per person) $_____
Specific Percentage Reimbursable (excess of deductible) _____%
Maximum Specific Excess Loss (per person in excess of Specific Deducible) $_____

SPECIAL LIMITATIONS

{MEDICAL DATA

The Company will rely on the data below to assist in approving the Employer for Reimbursement. Note that without the Company's review and approval of each risk, the Participating Employer's Losses will not be reimbursable under the Excess Loss Reimbursement Contract; therefore, please answer the following questions.

1. Has an eligible employee or dependent received or expected to receive more than 50% of the Specific Deductible in expenses in the last 12 months? ☐ Yes ☐ No
2. Will any former employee or dependent be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? ☐ Yes ☐ No

If yes to questions 1 or 2, list name, status, prognosis, and amount of claim (attach, sign and date a separate sheet if needed):

Name_____ DOB_____ Sex: ☐ Male ☐ Female Status_____
(Ee, Dep, COBRA, Retiree)

Diagnosis_____
Prognosis_____
Amount of Claim_____

3. Are expected benefits available from the prior insurer for presently disabled eligible employees and/or dependents? ☐ Yes ☐ No
4. Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? ☐ Yes ☐ No

Please explain any "Yes" answers to questions 3 or 4 (Please attach, sign and date a separate sheet if needed):

}

SIGNATURE

Application is hereby made to the National Employer's Excess Trust for Aggregate and Specific Excess Loss Reimbursement through Fidelity Security Life Insurance Company ("Company"). This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

It Is understood and agreed by the Applicant/Plan Sponsor that:

1. the Employer is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
2. the Third Party Administrator retained by the Applicant will be considered the Applicant/Plan Sponsor's Agent, and not the Company's Agent;
3. all documentation requested by the Company must be submitted prior to any approval of this Participation Agreement and must be received by the Company within ninety (90) days of the Effective Date;
4. the Company will evaluate the Employer's risk, and may require adjustments of rates, factors, and/or Special Limitations to accommodate for abnormal risks;
5. premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Insurance;
6. premiums will not be paid from the Employee Benefit Plan's assets;
7. this Participation Agreement will be attached to and made a part of any Excess Loss Reimbursement Contract issued by the Company in connection with this Participation Agreement;
8. the Employee Benefit Plan(s) attached shall be the basis of any Excess Loss Reimbursement Contract provided by the Company and such Employee Benefit Plan(s) conforms with applicable State and Federal laws;
9. any reimbursement under the Excess Loss Reimbursement Contract provided by the Company shall be based on covered expenses paid by the Plan Sponsor in accordance with the Employee Benefit Plan(s) attached;
10. the Employer's Losses for Plan benefits for any employee who is not at his or her customary place of employment (or scheduled vacation) on the Effective Date of the Excess Loss Reimbursement Contract will not be eligible for reimbursement under the Contract until such employee returns to active, full-time employment for at least one (1) full working day; and
11. the Employer's Losses for Plan benefits for any dependent, COBRA beneficiary, or retiree who is confined in a medical facility on the Effective Date of the Excess Loss Reimbursement Contract will not be eligible for reimbursement under the Contract until such person is discharged from the hospital or similar facility.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

In making this request for Excess Loss Reimbursement Contract, the Applicant/Plan Sponsor represents that such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant/Plan Sponsor to the proposed Contract. Accordingly, this request will be part of the Contract if accepted by the Company or is authorized representative.

Dated at _____ this _____ day of _____, _____

Witness _____ Employer_____
Signature of Licensed Agent (Type or Print)

Tax ID #_____

By _____
(Officer/Partner)

FIDELITY SECURITY LIFE INSURANCE COMPANY

Request for Continued Participation in the National Employer's Excess Trust for Excess Loss Reinsurance Coverage

Participating Employer: _____
Contract Number: _____
Contract Period from _____ **to** _____

Enrollment for the first month of the New Contract Period: Single _____ Family _____

AGGREGATE EXCESS LOSS ☐ Yes ☐ No

Benefit Period: Eligible Employee Benefit Plan expenses Incurred from _____ and through _____ and Paid from _____ and through _____ and is further subject to all terms and conditions of the Contract.

Aggregate Excess Loss includes: ☐ Medical ☐ Free Standing Drug Plan ☐ Dental Care ☐ Vision Care ☐ Other _____

Aggregate Percentage Reimbursable (Excess of Deductible)	_____ %
Maximum Aggregate Excess Loss	$_____
Monthly Aggregate Factors	Single _____ Family _____
Aggregate Premium Per Month	$_____
Aggregate Terminal Liability Premium	$_____
Monthly Aggregate Accommodation Premium	$_____

SPECIFIC EXCESS LOSS ☐ Yes ☐ No

Benefit Period: Eligible Employee Benefit Plan expenses Incurred from _____ and through _____ and Paid from _____ and through _____ and is further subject to all terms and conditions of the Contract.

Specific Excess Loss includes: ☐ Medical ☐ Free Standing Drug Plan

Specific Deductible	$_____
Specific Percentage Reimbursable (Excess of Deductible)	_____ %
Maximum Specific Excess Loss	$_____
Specific Premium Per Month	Single _____ Family _____

SPECIAL CONDITIONS AND/OR LIMITATIONS:

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

In executing this Continuance the Employer is acknowledging its acceptance of these new rates, factors and terms and further acknowledging that, except as stated separately with attachments, all material facts and conditions previously stated regarding the Plan and this Contract remain unchanged. **The above rates, factors and terms will be subject to change if this Continuance is not received within 10 days from the beginning of the Contract Period stated above.**

Dated _____ Employer _____

Title _____

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FDLT-126073799*	*State:*	*Arkansas*
Filing Company:	*Fidelity Security Life Insurance Company*	*State Tracking Number:*	*41853*
Company Tracking Number:	*A-01050AR(3/09)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Excess Loss Application*		
Project Name/Number:	*Excess Loss Application/A-01050AR(3/09)*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification — Approved-Closed — 03/19/2009

Comments:

Please see attached.

Attachment:

Readability Certification.pdf

Review Status:

Bypassed -Name: Application — Approved-Closed — 03/19/2009

Bypass Reason: Not applicable.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 03/19/2009

Bypass Reason: Not applicable.

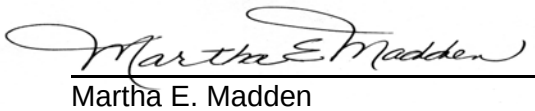
Comments:

FIDELITY SECURITY LIFE INSURANCE COMPANY
Kansas City, Missouri

I, AN OFFICER OF Fidelity Security Life, certify that the Flesch reading ease score for policy form(s) _____*_____ meets the minimum requirements of the NAIC Policy Language Model Simplification Act.

In accordance with the NAIC Model Act, certain language has been excepted. Such language includes the following: (a) name and address of Fidelity Security Life Insurance Company; name, number and title of the policy; index page; captions and subcaptions; specifications pages, schedules and tables; (b) all words defined in the policy; and (c) medical terminology, if applicable.

*	A-01050AR-(3/09)	50
	PA-00011AR	50
	PA-00004AR-CON	50



Martha E. Madden
Vice President and General Counsel

March 13, 2009
Date